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The management of poor performance in nursing and midwifery: a case for concern

Abstract

Aim(s) - To examine the evidence of how poorly performing nurses and midwives are managed in the UK NHS.

Background – There is little evidence about poor performance and its management in nursing and midwifery literature.

Method(s) – The scoping study comprised a literature search, analysis of recent Nursing and Midwifery Council data and a day's observation at NMC fitness to practice hearings.

Results – Nurses and midwives are the clinical groups most likely to be suspended from work in the NHS; NHS Trusts do not report data on suspensions therefore no statistics exist on numbers, reasons for suspensions, managerial processes, gender, area of work, or ethnicity of those suspended; the few major research projects identify variable management practices regarding poor performance, the significant financial cost to the NHS and the personal cost to those suspended; there is some evidence that inexperienced, poorly trained, or poorly supported managers use suspension inappropriately. Our day of observation supported this.

Conclusion(s) – There is a need for more robust data gathering and research in the field of NHS managerial practice.

Implications for Nursing Management – Managers should refrain from adopting punitive forms of performance management. Both frontline staff and management need better training and support for dealing with poor performance.

Aims

This paper sets out to summarise the most up to date evidence of how poorly performing nurses and midwives are managed in the UK NHS. This research was commissioned by the National Clinical Assessment Service, part of the National Patient Safety Agency. Originally set up in response to a number of high profile and financially and personally damaging suspensions of senior doctors, NCAS wished to investigate possible scope for extending its service to nurses and midwives, or groups within these professions. The research took the form of a comprehensive literature review carried out between January and June 2010. Although a great deal of anecdote exists regarding an apparent failure to manage this issue adequately within the NHS, the purpose of the review was to assemble robust research evidence on this topic.

Background

The issue of suspension of senior doctors in the NHS has caused considerable controversy. The most publicised cases have involved lengthy suspensions on full pay, sometimes known colloquially as 'gardening leave' (National Audit Office 2003)) for up to 10 years while

specific allegations are investigated, or suspensions for apparently trivial misdemeanours, such as the case of the 'crouton surgeon' in Nottingham who was suspended due to an over-serving of soup (Carvel 2004). While individuals may clearly perform poorly, many have suggested that organisational factors, including poor inductions or poor personal relationships, play a significant part in such cases (Meadows, Baker et al. 2004). Exclusions from work can be extremely costly to the organisation involved as there are financial implications for replacement as well as the cost of disciplinary procedures. They are also costly in personal terms to the suspended individual and in lowered morale for other employees (The Work Foundation, Aston Business School et al. 2009). In response to this problem the Department of Health issued a range of guidance for the management of poor performance of doctors and the National Clinical Advisory Agency (now NCAS) was set up to support poorly performing individuals (NCAA 2004). Suspension of nurses and midwives, as well as the former health visitors, has not been the subject of such policy attention until very recently. Nurses have been subject to local procedures by their employing Trust. Furthermore since the introduction of NHS Trust status in 1991, in cases of suspension, nurses no longer had a route of appeal to the former NHS regions.

Nurses and midwives represent the largest clinical group in the UK NHS and because of their close and constant interaction with patients have the greatest potential to influence patient experience and outcomes. In addition, partly as a result of health policy over the last 12 years, their field of responsibility has been growing, for example, to include the powers to prescribe medicines. Nurses also manage various services, often for the chronically ill and run technical investigative services such as endoscopy. As is the case with the other professional groups involved in healthcare, the vast majority of nurses and midwives are highly skilled and conscientious practitioners and the number of those who represent a cause for concern appears to be extremely small. Those involved in investigations by the Nursing and Midwifery Council (NMC) amount to 0.2% of nurses (Nursing and Midwifery Council 2009). Nevertheless, unacceptable or dangerous practice, whether through lack of training or support, illness, lack of motivation or ill-intent has potentially grave consequences. This is particularly serious as nurses are charged to care for some of the most vulnerable in society such as children and the elderly. Some nurses and midwives work alone with high degrees of decision-making autonomy and less access to professional development and the scrutiny of colleagues. There are calls for nurses' roles to expand further and for an increased presence in community settings. For all these reasons there is a need for a high quality, effective and consistent approach to the management of performance concerns in the NHS, both across trusts and across different professional groups.

NCAS recently defined performance concerns as: 'any aspects of a practitioner's performance or conduct which:

- pose a threat or potential threat to patient safety;
- expose services to financial or other substantial risk;
- undermine the reputation or efficiency of services in some significant way;

- are outside acceptable practice guidelines and standards.’ (National Clinical Assessment Service 2010) p.2.

To work in the UK, all nurses, midwives and specialist community public health nurses must register with the Nursing and Midwifery Council (NMC) and renew their registration every three years. The United Kingdom Central Council for nursing, midwifery and health visiting, itself only created in 1983 was replaced in 2002 by the Nursing and Midwifery Council (NMC). The intention was to ‘sharpen accountability and streamline regulation’ ((Department of Health 1999), p. 58) however it was not a smooth transition with the NMC in 2008 being accused of bullying and racism. Coupled with this there have also been changes within the NHS over the last two decades with what many have seen as a steady rise in managerial power (Pollitt 1993; Berg 2006). Some have observed that nurses who have taken on general management roles can be under pressure to abandon a loyalty to their own profession in order to be seen as effective corporate players (Traynor 1999) and this may have implications for how nurse managers approach discipline within their own professional group.

This background of policy concern regarding the management of poorly performing doctors coupled with changes within the nursing professions points to a need to update the current evidence base regarding the management of poor performance in nursing.

Methods

The chief method of data collection for this scoping study was a comprehensive literature review. This consisted of looking for both published and grey literature which explored various aspects of poor performance and its management in nursing and midwifery. A parallel study which aimed to gather stakeholder views was also commissioned by NCAS and undertaken by a research consultancy. (For details see www.opinionleader.co.uk/news.asp?pageid=578&page=3). The present paper deals only with our literature review.

Our search terms comprised poor performance; fitness to practice; underperformance; remediation; poor practice; malpractice; monitoring performance; performance concerns; discipline; nursing; midwifery; primary care; patient safety; mental health; district nurse; health visitor; specialist nurse and nurse consultant. Due to the small amount of literature in this area on occasion it was not necessary to combine search terms. All abstracts of the articles retrieved from the initial extraction process were read carefully by two members of the research team and if matching the topic criteria were included and deemed relevant for further reading. Efforts were made to obtain all relevant studies. However, the absence of subject indexing terms and structured abstracts in many electronic databases meant that the

search and retrieval process was sometimes more lengthy. We recognise that not all articles that successfully filter through the search criteria will be available. All articles retrieved were in English. We searched 7 electronic databases; PubMed, Cochrane library, HMIC, British Nursing Index, MEDLINE, CINAHL, Web of Science (WoS) databases. We also searched Google Scholar and 11 Internet sites, including a site which collated personal accounts of suspensions in the NHS. The most recent three years of journals that were considered important in the field such as Journal of Nursing Management, Nursing Times and Nursing Standard were hand-searched and we also used the on-line resources of the National Audit Office, the NMC and Department of Health. Reference checking was also an integral process in extracting data. All articles in languages other than English were noted together with any studies that the team was unable to retrieve. The search process produced 6,137 initial hits, not including duplicates, and of these 146 were relevant to the study. On further reading 68 studies remained and form the basis of this paper.

In addition, we observed one day of fitness to practice cases at the NMC and we analysed the most recent 6 months of NMC fitness to practice case reports. This data, which is publicly available, was summarised according to: part of the register of the respondent, gender; the type of employer e.g. primary care trust, private sector (if known); country; date; the reason for the hearing; whether this reason is clinical, non-clinical or both; and the result of the hearing. Finally, we also contacted and sought the views of some of those who had conducted major research in the area.

Results

Our most significant overall finding was that there is a double absence: both of recorded data on suspensions of NHS staff and of systematic research into the topic. We retrieved three significant studies on the topic and a number of other works of peripheral relevance. We now summarise studies which examine the prevalence of suspensions and the outcomes.

Prevalence and outcome studies

The National Audit Office (NAO) report (National Audit Office 2003) on the management of poor performance of clinicians in NHS hospital and ambulance trusts is the only recent major national study on the topic. The study found that between April 2001 and July 2002, 562 nurses and midwives were suspended for at least one month. This amounted to 53% of total NHS staff suspensions. Nurses were more likely to be formally suspended than doctors, and their average length of suspension was nineteen weeks. (Table 1)

TABLE 1 ABOUT HERE

The report found that 'most trusts (86 per cent) carried out an initial investigation before excluding a clinician but the quality and rigor of these varied, with initial investigations following decisions to suspend staff. Where patient safety is at risk swift suspension may be appropriate, but in the majority of cases reported to us by the trusts, patient safety was not

an issue, and the decision to exclude is sometimes a knee-jerk reaction made by trusts without sufficient investigation' (p25). Two thirds of Trusts used guidance from the Department of Health as a basis for their procedures but respondents in a quarter of the Trusts felt that this guidance was of little use. Common criticisms were that the guidance was too lengthy, complex, legalistic and difficult to follow. Some Trusts had developed their own guidance for initial investigations and consideration of options prior to suspension. The Arbitration Conciliation and Advisory Service (ACAS) guidance (issued in 1997) was also used by some Trusts to develop local policy for managing suspensions. The lack of or confusion regarding guidance for nurse suspensions was found to have led to procedures that were open to individual manager interpretation and abuse. This report concluded that the management of suspensions and exclusions from work in hospital and ambulance trusts was inconsistent and sometimes extremely poor, with managers showing widespread ignorance of national guidance on the topic. There was also highly incomplete reporting of the costs of suspensions.

A PhD study undertaken by Rachel Murray completed in 2005 examined the experience of nurses suspended from the workplace (Murray 2005). Her research consisted of three elements; a survey of nurse suspensions known to the Royal College of Nursing in England during 2002, an audit of 637 sets of Royal College of Nursing Counselling Service data using the Clinical Outcome Routine Evaluation (CORE) System, and analysis of individual interview and focus group data from sixty-three self-selected participants who had experienced suspension. Survey results indicated that there were 207 known nurse suspensions in England in 2002, equating to 1 for every 1500 RCN members. Some 45% of these were the result of complaints from colleagues. Murray found that the majority of suspended nurses returned to work after the disciplinary hearing and only 18% were dismissed. The length of suspension varied from two weeks to over six months. She found an inconsistent approach to the use of suspensions. There were also issues surrounding preliminary investigations with some nurses being suspended after a complaint was received without being told of the nature of the allegations. The CORE System audit results pointed towards psychological distress and risk as higher in incidence and effect for nurses being investigated for alleged misconduct than for working nurses. The likelihood of suspension appeared to increase for nurses who were older i.e. aged over forty, and/or were male, and/or from a black minority ethnic group. Murray's literature review included studies that had linked suspension with bullying, often by managers (Doherty 2003) and low morale. Low morale was an emergent theme for pre-suspension nurses in her study.

Her analysis of interviews and focus groups revealed that staff shortages, increased workload, bullying and harassment, and discordant interactions with colleagues or managers increased the likelihood of complaints and as a consequence, suspension, in the pre-suspension stage.

Cooke's work focuses on aspects of healthcare management and disciplinary processes. One study involved observation in three healthcare Trusts in the north of England with

interviews being held with ward sisters, staff nurses, clinical nurse specialists, directorate managers and others discussing any form of involvement in disciplinary procedures (Cooke 2006). Findings show that punishments were commonplace but not necessarily documented, as Cooke states, 'quasi-formal discipline is often unofficial or semi-official and may happen out of the gaze of Trust board managers. It is not captured in official reports on the incidence of disciplinary cases' (p697). Therefore it appears that to avoid high numbers of disciplinary actions and high costs for disciplining nursing staff quasi-official procedures take precedence keeping the actual figures of poor performance/underperformance under the radar and out of the public domain. Cooke also noted that those workers that were required to attend formal disciplinary meetings, and as a result resigned or were dismissed, often went on to work in the nursing home sector. Comments were also made by her respondents regarding the apparent defensiveness of NHS culture around this topic which Cooke speculates was attached to the newly self-governing Trusts who were able to discipline and suspend staff based on their own guidelines rather than national ACAS guidelines. Cooke also discussed remediation (Cooke 2006). She developed a typology of existing approaches to the management of poor performance in nursing finding that punitive authoritarian discipline was the most popularly adopted model in the trusts involved in her study even though there was little or no evidence in the employment literature to show that this was effective in improving performance.

Costs of suspension

A small number of studies have attempted to measure the costs of the management of poor performance for the NHS and in some cases the costs specific to nursing and midwifery can be identified. (Table 2)

TABLE 2 ABOUT HERE

Less tangible costs for organisations include overall loss of efficiency linked with poor performance and heavy workloads often associated with suspensions, the effects on productivity and quality of care of lowered morale (The Work Foundation, Aston Business School et al. 2009) and increased anxiety experienced by staff with knowledge of suspended colleagues and possible extra recruitment costs as turnover following a suspension may increase. Suspended individuals experience their own financial costs associated with reduced income (suspended individuals will not accrue shift or other benefits) and possible medical and counselling treatment costs of stress or depression associated with suspension.

An accurate up to date estimate of the cost to the NHS of managing poor performance among nurses and midwives was not available. Therefore we have turned to the best available and most recent evidence to address this question. (Table 3)

TABLE 3 ABOUT HERE

The NAO report notes that the research team's validation work indicated that trusts significantly under-reported the costs of exclusions. The figures cited above make allowance for this and the cost of settlements. Their survey was undertaken in NHS hospital and ambulance trusts and did not include primary care trusts which employ nurses and midwives in more lone and autonomous roles where it is possible that the level of suspensions would be higher.

Murray (Murray 2005) applied the cost estimates from the NAO report to calculate that the total cost to employers of the 207 nurse suspensions known to the RCN during 2002 would have been in the region of £4,429,800.

In July 2006 the Daily Mirror reported on its investigation, using the Freedom of Information Act, to claim that up to 375 nurses, 152 doctors and 35 other clinical staff were currently suspended on full pay from hospitals and GP surgeries (Roper 2006). The report claimed that the total cost to the NHS of these suspensions was 'upto £100M per year' and that the annual cost of each suspension of a doctor was £500,000 and £50,000 per nurse including pension costs, legal and administrative costs and the cost of providing locum cover. According to these figures, the cost of suspensions of nurses was £18,750,000. No further details of the costing methodology are available.

The effects of suspension

According to Murray (Murray 2005), the moment of suspension was experienced by suspended personnel as a traumatic event with ongoing chronic and acute emotional responses of shock, anxiety, anger and distress. During the time at home when suspended nurses were banned from the workplace and from contact with colleagues, three emotional processes emerged: a post-trauma reaction, an adjustment to loss response and an identity threat. The time at home ended with the hearing and outcome stage in which concerns emerged about the length of time suspended and the few dismissals calling into question the need for suspension with its attendant psychological and financial cost. The post-suspension experience centred on reintegration to work and the process of sense and meaning making. Murray asked her participants what would have made a positive difference to their experience. Informants' responses suggested that formal and informal means of support were necessary for all involved, but crucially for the nurse during suspension and on return to work through a structured rehabilitation. As initiators of suspension she suggested that employers carry a legal and moral responsibility for providing this support. She found that managers' interpretation of gross misconduct was a crux issue and manager actions were identified that were helpful and unhelpful. She recommended that disciplinary systems needed streamlining with monitoring with accountability structures. Implications for the Royal College of Nursing were increased support and training for staff and activists, and counsellor flexibility in terms of the number of sessions offered to suspended nurses.

Though anecdotal in character, Fagan has collected personal accounts of the effects of suspension from NHS employees (Fagan 2004). These support the conclusions drawn by researchers that suspension has a strongly negative effect on those who experience it in financial, personal and professional terms.

Discussion

This work has served to highlight the lack of empirical data on the topic of poor performance with the relatively few research works on this topic emphasising the varied ways in which performance is managed ranging from the 'quasi-formal' approaches which Cooke discusses to the 'knee-jerk' responses of managers detailed by the NAO.

National guidelines and local NHS policy alike emphasise that patient safety should be of primary importance when managing cases of poor performance. The research studies of Cooke (Cooke 2006; Cooke 2006), the National Audit Office (National Audit Office 2003) and personal accounts included in a document by Fagan (Fagan 2004) as well as NMC data, however, suggest that suspensions and exclusions are often the procedure of first choice for managers concerned about aspects of clinical behaviour. This appears to be true even when such issues do not appear to directly threaten patient safety.

The primary concern which emerges from the literature is that it is impossible to ascertain precisely how many nurses and midwives are poorly performing or how this is tackled by management within NHS trusts as all have varied approaches. Although there is guidance for trusts (National Clinical Assessment Service 2006) their policies and procedures are self-directed meaning that some will have a much greater emphasis on support, mentoring programs and remediation for those employees poorly performing whilst others may have very few systems in place to support those in difficulty. Studies of errors in nursing have concluded that most errors occurred not because nurses were reckless or lacked training but because organisational systems were not designed to prevent errors from occurring ((Henry 2000); (Oulton 2003)), however should errors occur it is important that the nurse has an avenue of support, fully comprehends what went wrong and can be helped to ensure it is not repeated. The latter points appear greatly lacking within the UK NHS.

Conclusion

Our scoping suggests that the management of poor performance in nursing and midwifery, along with aspects of current practice around suspension and exclusion from work, is variable and there is existing evidence of unsatisfactory practice. This finding, points to a need for better data reporting requirements in this area such as recording of reason, length and outcome.

Implications for nursing management

1. There is no detailed national data on suspensions and exclusions for nurses and midwives and there appears to be no effective requirement on NHS and other organisations to report to the Department of Health all cases of suspensions of nurses and midwives, including reason, length of suspension and outcome. Therefore we recommend that this requirement would enable a more effective monitoring of this situation. The single improvement may also, of itself, lead to better management of poor performance.
2. Managers should refrain from adopting punitive forms of performance management to deter poor performance as this has been shown to have little to no effect. Approaches which are based on understanding errors as a combination of human and system factors should be taken up and this should be monitored (see recommendation 1).
3. Research and personal accounts have shown that suspended nurses or midwives may be unaware of the full reasons for their suspension. Managers should ensure that any disciplinary action that is/has taken place is made clear to the workers involved along with the reasons why and full explanations of the process.
4. Human Resource departments within NHS trusts and other healthcare providers should engage with training to ensure they can deal with performance issues in the most effective manner and provide support for managers involved in the suspension process. In addition a structured system should be put in place - and followed - in each organisation based on national guidance from NCAS to ensure clarity and transparency when tackling poor performance.

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